U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 29Jan2002

In the Matter of	:	
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DOLORES E. KLEE, Widow of	:	
ROBERT L. KLEE, Dec'd.,	:	Case Number: 1999-BLA-1173
Claimant,	:	
	:	
v.	:	
	:	
PEABODY COAL COMPANY,	:	
Respondent,	:	

Vernon L. Plummer, II, Esquire
For the Claimant

Richard R. Risse, Esquire
For the Respondent

Before: EDWARD TERHUNE MILLER
Administrative Law Judge

DECISION AND ORDER DENYING CLAIM

Statement of the Case

This proceeding involves a survivor's claim for benefits under the Black Lung Benefits Act as amended, 30 U.S.C. §§ 901 *et seq.* ("the Act"), and the regulations promulgated thereunder.[1] Since this claim was filed after March 31, 1980, Part 718 applies. §718.2. This claim is governed by the law of the Seventh Circuit of the United States since the deceased miner was last employed in the coal industry in Illinois. *See Shupe v. Director, OWCP*, 12 B.L.R. 1-202 (1989)(*en banc*). Because this claim was pending when Part 718 and Part 725 of the Regulations were amended, effective January 19, 2001, it is

[1] All applicable regulations which are cited are included in Title 20, Code of Federal Regulations, unless otherwise indicated, and are cited by part or section only. Director's Exhibits are denoted "D-"and citations to the hearing transcript are denoted "Tr."

considered and decided under the amended regulations. 65 Fed. Reg. 80,045 (December 20, 2000).

The deceased miner, Robert L. Klee (the "Miner"), filed his first application for benefits under the Act on May 26, 1973. His application was denied by the Department of Health, Education and Welfare on September 4, 1973. It was similarly denied by the office of the District Director in Johnstown, Pennsylvania for lack of evidence of pneumoconiosis or total disability due to pneumoconiosis. (D-28).

The Miner filed a second application for Federal Black Lung Benefits on July 5, 1996, which was denied by the District Director's office on January 7, 1997 for lack of evidence of total disability due to pneumoconiosis, and became final in the absence of an appeal (D-29).

The Claimant, Dolores E. Klee, filed for Federal Black Lung Survivor Benefits on June 3, 1998 (D-1). The District Director filed a Notice of Initial Finding of Eligibility on October 6, 1998 (D-10). After reviewing additional medical evidence consisting of the December 12, 1998 consultive report of Dr. Kleinerman, the District Director reversed the Notice of Initial Finding of Entitlement on January 15, 1999, explaining that the finding of complicated pneumoconiosis which depended upon Dr. Hindman's autopsy report could no longer be supported (D-17).

Thereafter, following an informal conference held on April 8, 1999, the District Director reversed his findings again, after determining that the additional medical evidence submitted after the informal conference supported the finding of complicated pneumoconiosis, and, therefore, death due to pneumoconiosis (D-24). The Memorandum of Conference was issued on June 28, 1999 (D-24). The Employer, Peabody Coal Company, requested a formal hearing on July 9, 1999, and the claim was referred to the Office of Administrative Law Judges on July 27, 1999 (D-25, 30).

A formal hearing was held on October 23, 2000 in Springfield, Illinois. At the hearing, Director's Exhibits one (1) through thirty (30) and Employer's Exhibits one (1) through ten (10) were admitted into evidence. The Claimant objected to the admission of Employer's Exhibits four (4) and ten (10), x-ray readings by and a deposition transcript of Dr. Renn, on grounds that he read copies of x-ray films rather than the original films as required by §718.102(d). The Exhibits were conditionally admitted into the record pending the decision of this tribunal upon further investigation into Dr. Renn's use of copied films. (Tr. 6-13). The Claimant and two of her daughters testified regarding the Miner's work history and medical treatment (Tr. 18-42).

ISSUES

1. Whether the Miner had complicated pneumoconiosis as defined in §718.304, and, is therefore, entitled to the irrebuttable presumption that his death was due to pneumoconiosis
2. Whether pneumoconiosis was a substantially contributing cause or factor leading to the Miner's death.
3. Whether Dr. Renn's interpretations of x-ray film copies, as opposed to the original films, are inadmissible as evidence.

FINDINGS OF FACT, DISCUSSION, AND CONCLUSIONS OF LAW

Background

The Miner, Robert L. Klee, was born on August 18, 1923 and completed nine and one-half years of education (D-28, 29). The Miner married the Claimant, Dolores E. Klee, on October 25, 1947, and they remained married until the Miner's death (D-1; Tr. 18). The Miner worked for at least thirty-five years in the coal mine industry. The parties stipulated to this employment history, which is supported by the record, at the informal conference on April 8, 1999 (D-24). The Miner last worked in the coal mine industry in March of 1988 when he retired (D-29). At the hearing, Claimant testified that the Miner worked underground as a shuttle car operator and a miner operator (Tr. 19). She also testified that Peabody Coal Company was the Miner's only Employer in the coal mine industry (Tr. 26).

The Miner reported a smoking history of forty to fifty years at a rate of one to two packs of cigarettes per day (D-16, 29). The Miner was diagnosed with lung carcinoma with apparent synchronous primaries in June of 1996 (D-29). The Miner died on April 10, 1998 at his home in Pana, Illinois. (D-3). The cause of death listed on the death certificate (Part I) was pulmonary thromboembolism to the right lung. Bilateral chronic coal workers' pneumoconiosis and pulmonary emphysema were listed separately as "Other significant conditions contributing to death but not resulting in the underlying cause given in Part I."

Findings of Fact - Medical Evidence

The Admissibility of Dr. Renn's X-ray Interpretations

At the hearing, Claimant objected to and requested exclusion of x-ray readings from Dr. Renn contained in his January 5, 2000 report on the basis that the chest x-rays were copied films. Claimant also objected to the admission of Dr. Renn's deposition testimony at E-10 on the same grounds. (Tr. 6-9, 47-48). This tribunal noted at the hearing that it would take the objection under advisement and would conditionally admit Dr. Renn's report and deposition transcript (Tr. 52). Upon review of Dr. Renn's testimony as a B-reader that the copies of the x-rays were the only x-ray provided to him and were of sufficient quality for determining the presence or absence of pneumoconiosis, this tribunal finds pursuant to pre-amended §718.102(e), that Dr. Renn's x-ray interpretations found in his report at E-4 and corresponding deposition testimony at E-10 are admissible.[2]

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[2] The former §718.102(e) provided in pertinent part:

> In the case of a deceased miner where the only available X-ray does not substantially comply with paragraphs (a) through (d), such X-ray may form the basis for a finding of the presence or absence of pneumoconiosis if it is of sufficient quality for determining the presence or absence of pneumoconiosis and such X-ray was interpreted by a Board-certified or Board-eligible radiologist or a certified "B" reader.

X-rays[3]

Exhibit	Date of Film	Date of Reading	Physician/ Qualifications	Interpretation
D-28	7/6/73	7/6/73	Collodi R	Negative
D-29	2/2/96	5/29/96	Williams R	1.5 x 1.2 cm. nodule in right apex and 1.5 cm. nodule in left apex
D-29	5/26/96	9/23/96	Gaziano B	1/2, r/r, upper lung zones; no large opacity
D-15	5/30/96	10/3/98	Wiot B/R[4]	1/1, q/t, mid and upper lung zones; large A opacities; large opacity in right apex probably carcinoma and left apex looks like residua of old inflammatory disease, most likely pulmonary tuberculosis
D-29	5/30/96	10/14/96	Gaziano B	1/1, q/r, mid and upper lung zones, large opacities A, coalescence
D-29	5/30/96	12/19/96	Gaziano B	1/1, q/r, all six lung zones, no large opacity, cancer
D-29	5/30/96	5/30/96	Muehle R	Small pneumothorax, right upper lobe nodule identified, left upper lobe nodule is a little more conspicuous presumably secondary to some hemorrhage about the nodule following a chest biopsy
D-15	5/31/96	10/3/98	Wiot B/R	1/1, q/t, mid and upper lung zones; large A opacity is carcinoma and left is TB
D-29	5/31/96	10/14/96	Gaziano B	1/1, q/r, all six lung zones, large A opacity
D-29	5/31/96	12/19/96	Gaziano B	1/1, q/q, all six lung zones, no large opacity, cancer

[3] The following abbreviations are used in describing the qualifications of the physicians: B-reader, "B"; Board-certified radiologist, "R."

[4] Dr. Wiot reviewed a set of four films dated May 30, May 31, June 3, and August 5, 1996 and the May 26, 1996 CT for consultive reports dated October 3, 1998 and November 12, 1998 (D-15). In his report of November 12, 1998, Dr. Wiot explained that in his original report for the four x-ray films, he had his right and left sides confused. Therefore, he corrected himself, stating that the characteristic malignancy is on the left side and the post-inflammatory difficulties are on the right.

D-15	6/3/96	10/3/98	Wiot B/R	1/1, q/t, mid and upper lung zones; large A opacity; TBC LUL?; ill defined RUL obscuring nodule; pneumothorax; left density persists, again appearing to be more an inflammatory process than large opacity
D-29	6/3/96	10/14/96	Gaziano B	1/1, q/r, all six lung zones, large A opacity
D-29	6/3/96	12/19/96	Gaziano B	1/1, q/r, all six lung zones, no large opacity, cancer
D-29	6/4/96	10/14/96	Gaziano B	1/0, q/q, mid and upper lung zones, no large opacity, coalescence
D-29	6/4/96	12/19/96	Gaziano B	1/1, q/q, all six lung zones, no large opacity, cancer
D-29	6/4/96	6/4/96	Muehle R	Postoperative expanding right pneumothorax
D-29	6/4/96	6/5/96	Lake R	Residual pneumothorax on the right, bilateral apical nodules, some reticulonodular infiltrate likely old fibrosis
D-15	8/5/96	10/3/98	Wiot B/R	1/1, q/t, mid and upper lung zones; large A opacity, RUL cancer, probable old TBC left apex
D-29	8/5/96	10/14/96	Gaziano B	1/1, q/r, mid and upper lung zones, large A opacity
D-29	8/5/96	12/19/96	Gaziano B	1/1, r/r, mid and upper lung zones; no large opacity, cancer
D-29	8/5/96	8/11/96	Williams R	1 cm. nodule RUL, several smaller nodules on left
D-22	10/28/96	5/20/99	Alexander B/R	Complicated pneumoconiosis, category A, p/q, 1/2, coalescence, pleural thickening; unilateral chest wall pleural thickening

D-14	10/28/96	10/29/96	Cull R	Compared to 6/3/96; again identified pulmonary nodule in right upper lobe; overall size of the nodule is unchanged; there is a smaller nodular density projecting in the left upper lobe, it is too small to accurately characterize
E-4	10/28/96	1/6/00	Renn B	1/1, p/q, mid and upper lung zones, cancer LUL; there is a RUL lesion measuring 1.5 x .8 cm. with a radiation to the R sup. hilum indicating that it is likely inflammatory. There is no surrounding bullae. No large opacities
D-22	11/18/96	5/20/99	Alexander B/R	Complicated pneumoconiosis, category A, p/q, 1/2, coalescence, pleural thickening, unilateral chest wall pleural thickening
D-14	11/18/96	11/19/96	Cull R	No change since 10/28/96 study
E-4	11/18/96	1/6/00	Renn B	1/1, q/r, mid and upper lung zones, cancer LUL; there is a RUL lesion measuring 1.5 x .8 cm. with a radiation to the R sup. hilum indicating that it is likely inflammatory. There is no surrounding bullae. No large opacities
D-14	1/14/97	1/14/97	Ambrosini R	Ill defined 1 x 2 cm. nodule in the right upper lung which has not changed significantly since 5/26/96. Previously seen nodule on the left upper lung field is not visualized at the time. No other pulmonary mass is seen and there are no acute infiltrates or effusions at this time.
D-22	4/9/97	5/20/97	Alexander B/R	Complicated pneumoconiosis, category A, p/q, 1/2, coalescence, pleural thickening, unilateral chest wall pleural thickening
D-25	4/9/97	6/30/99	Wiot B/R	1/1, q/t, mid and upper lung zones, cancer, no large opacities

D-14	4/9/97	4/9/97	Cull R	Minimal nodularity demonstrated most prominently in the upper lung fields; slightly irregular area of nodularity in the left upper lung field, 1 cm. in diameter
E-4	4/9/97	1/6/00	Renn B	1/1, p/q, mid and upper lung zones, cancer LUL enlarging since 11/18/96; there is a RUL lesion of 1.5 x .8cm. with radiation to the R sup. hilum indicating that it is likely of an inflammatory etiology. There are no surrounding bullae. .9 x .8 cm. nodule in LLL overlying the L 8th posterior rib. No large opacities
D-22	6/11/97	5/20/99	Alexander B/R	Complicated pneumoconiosis, category A, p/q, 1/2, coalescence, pleural thickening, unilateral chest wall pleural thickening
D-25	6/11/97	6/3/99	Wiot B/R	1/1, q/t, upper lung zones, cancer, no large opacities
D-14	6/11/97	6/12/97	Cull R	Small nodule in left upper lung field on identified in previous study has decreased in size and is difficult to identify; two or three other nodules in left apex are unchanged
E-4	6/11/97	1/6/00	Renn B	1/1, q/r, mid and upper lung zones, cancer LUL; there is a RUL lesion of 1.5 x .8cm. with radiation to the R sup. hilum indicating that it is likely of an inflammatory etiology. There are no surrounding bullae. .9 x .8 cm. nodule in LLL overlying the L 8th posterior rib. No large opacities

CT Scan Reports

Exhibit	**Ct Scan Date/ Reading Date**	**Physician/ Qualifications**	**Interpretation**
D-15	5/26/96/ 11/12/98	Wiot B/R	The changes noted here are those of simple coal workers' pneumoconiosis. The masses described are not characteristic of large opacities, but rather are most characteristic of malignancy and old granulomatous disease, as there is no evidence of emphysema associated with either one. The CT scan shows a new nodule remote to the nodules previously described on the right, which shows characteristics of a second primary, or perhaps metastatic lesion.
D-22	5/30/96; 6/3/96/ 5/20/99	Alexander B/R	The right upper lobe mass measures approximately 20 x 10mm. Its shape and adjacent fibrotic retraction favor a conglomerate mass of complicated coal workers' pneumoconiosis. The left upper lobe mass is suspicious for lung cancer, although it could also be cased by complicated coal workers' pneumoconiosis. Please correlate with the pathology of the biopsy specimens.
D-25	6/3/96/ 6/30/99	Wiot B/R	Small nodules consistent with simple coal workers' pneumoconiosis involving the upper and mid zones. There are no large opacities identified in this patient and no evidence of complicated coal workers' pneumoconiosis.
E-4	5/30/96; 6/3/96/ 1/5/00	Renn B	The CT scans reveal changes consistent with a simple pneumoconiosis. The left upper lobe reveals a mass lesion consistent with a malignancy. There is a right upper lobe lesion which is irregular, had radiation to the periphery and toward the right hilar area. It is consistent with an old inflammatory process. There are no findings of emphysema.

Pulmonary Function Studies[5]

Exhibit	Date	Physician	Ht/age	FEV_1	FVC	MVV	Qualifying
D-14, 29	5/30/96	Gumprecht	67"/72	2.39 2.57	3.98 4.06	63 61	No

Arterial Blood Gas Studies

Exhibit	Date	Physician	pO_2	pCO_2	Qualifying
D-14	5/29/96	Gumprecht	69.0	38.9	No
D-14	5/31/96	Gumprecht	71.0	37.0	No

Medical Reports and Opinions[6]

Dr. Stephen A. Mayer, board-certified in internal medicine and the subspecialties of cardiovascular disease and interventional cardiology, performed a heart catheterization on the Miner at Memorial Medical Center in Springfield, Illinois on May 28, 1996. He found normal ventricular function. In a letter dated June 3, 1996, Dr. Mayer explained to the Miner's treating physician, Dr. Alfred Harney, the Miner's emergency admission to Memorial Medical Center for chest pain and his subsequent treatment. Dr. Mayer explained that on review of the CT scan performed to rule out aortic aneurysm and aortic dissection, a nodule was seen and the Miner was treated by Dr. Donald Gumprecht. Dr. Gumprecht performed a CT directed lung biopsy which was positive for malignancy. The Miner was going to follow-up with treatment by Dr. Gumprecht as an outpatient. (D-14 at 63-65).

Dr. Donald Gumprecht, board-certified in internal medicine and the subspecialties of critical care and pulmonary disease, wrote his final notes at Memorial Medical Center in Springfield, Illinois on May 31, 1996. The last pulmonary progress note states that the left upper lung nodule had a positive preliminary cytology. After noting that the Miner had good lung function, he stated that the lung should be resected if possible. (D-14 at 143).

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[5] The second set of listed values relates to post bronchodilator test results.

[6] The professional credentials of Drs. Mayer, Gumprecht, Braud, Kozloff and Fields are not in evidence. However, this tribunal takes judicial notice that their relevant qualifications are disclosed on the worldwide web, American Board of Medical Specialties, Who's Certified Results, at http://www.abms.org. *See Maddaleni v. Pittsburgh & Midway Coal Mining Co.*, 14 B.L.R. 1-135 (1990).

Dr. Edward L. Braud, board-certified in internal medicine and the subspecialty of medical oncology, first saw the Miner on June 12, 1996 for consultation concerning possible treatment of his lung cancer. In his office note of that consultation, he wrote that the Miner was a retired coal miner who smoked about one pack of cigarettes per day for forty years. Physical examination revealed that the lung fields were clear. He had generalized decreased breath sounds, but no evidence of edema, clubbing or cyanosis. Dr. Braud reviewed the chest-x-rays and the treatment records of Dr. Gumprecht. He assessed the Miner to be a seventy-one year old man with what apparently represented bilateral synchronous primaries in the right and left lung apices. The left lung was read positive for non-small cell carcinoma. The right lung apex was read as highly suspicious. (D-29 at 27).

Dr. Braud met with the Miner and his family on June 19, 1996 as a follow-up visit to discuss treatment options. A more recent CT scan of the abdomen and pelvis revealed a small left lung base nodule suspicious for pulmonary metastases and a questionable nodule in the right lung base. Dr. Braud noted that he reviewed the CT scans with the Miner and his family, and that he pointed out on chest x-ray the lesions noted in the chest. Dr. Braud also stated that he informed the Miner and family of treatment options alternative to surgery because it appeared that he had metastatic disease and was not a surgical candidate based on his lung disease. Dr. Braud noted that a second opinion was scheduled for July 8 in Chicago. (D-29 at 26).

Dr. Braud met with the Miner a third time on August 5, 1996. His diagnosis was unresectable lung carcinoma based on the fact that the Miner had apparent synchronous primaries. He noted that Dr. Gumprecht performed a biopsy which showed a mass in the left upper lobe which was positive for malignant cells and a lesion was noted on the right apex by Dr. Christy, which was interpreted as being highly suspicious for malignancy. Dr. Braud planned a series of chemotherapy treatments and a follow-up visit in three weeks for re-evaluation and treatment. His assessment was: Unresectable non-small cell lung carcinoma. (D-29 at 25).

Dr. Mark F. Kozloff, board-certified in internal medicine, provided a second opinion for the Miner on July 8, 1996. By letter dated July 23, 1996, Dr. Kozloff indicated that he saw the Miner on July 8, 1996 for a consultation for a second opinion. Dr. Kozloff stated, "He has non small cell lung cancer, chronic lung disease, and his chest x-ray is suggestive of pneumoconiosis." (D-29 at 21).

Three biopsies were performed on the Miner in 1996. (D-14, 29). A CT guided biopsy was performed on a left upper lobe nodule on May 30, 1996. The cytology report provided by Dr. Philippine Brooke was positive for malignant cells. The cytology report for the June 3, 1996 biopsy of an indeterminate lesion in the right lung apex indicated a "single cluster of highly suspicious cells" and Dr. Brooke determined that the lesion was "suspicious for malignancy." A cytopathology report from a July 9, 1996 biopsy of what appears to be both lungs noted malignant cytology of the left upper lobe mass consistent with adenocarcinoma. The right lung apex mass was found to be dilute and was essentially an unsatisfactory specimen. Rare atypical cells were present and a reaspiration was suggested.

Dr. Sarah Long, internist, reviewed the medical records in the living Miner's claim. Dr. Long opined, in her report of October 8, 1996, that the Miner was not totally disabled, stating, "the PFTs of 5-30-96 show values well above the 718 standards. There is no indication that this man is totally disabled due to a pulmonary impairment. He has bilateral carcinoma of the lung. However, at the time of 5-30-96 evaluation he was not disabled by this." (D-29 at 19).

Dr. Joseph N. Fields, board-certified in therapeutic radiology, examined the Miner in consultation on August 20, 1997. He noted the biopsy evidence of non small cell carcinoma in the left upper lobe as well as a lesion highly suspicious for malignancy in the right lung apex. He noted that Dr. Braud also found evidence of suspicious soft tissue nodules in each lung base. Dr. Fields recorded that the Miner had received several cycles of chemotherapy, noting a decrease in the size of the left upper lobe mass, but persistence of the left lung base nodule. Dr. Fields noted evidence on MRI scan of multiple bilateral metastases involving the cerebrum and cerebellum. His impression was: Adenocarcinoma with symptomatic central nervous system metastases. He noted that the Miner agreed to undergo radiation therapy over a period of two and one-half weeks. (D-14 at 93-94). Dr. Fields noted in his office visit of September 8, 1997 that the radiation therapy to the brain had been completed in nineteen days (D-14 at 92).

Dr. Travis L. Hindman, board-certified anatomical and clinical pathologist, performed the autopsy on the Miner on April 10, 1998. His report of May 2, 1998 indicated that the final diagnostic cause of death was pulmonary thromboembolism with high grade obstruction of the pulmonary vasculature to the right lung. He also found that severe bilateral coal workers' pneumoconiosis with multiple large and small macules, along with bilateral pulmonary emphysema were significant contributing factors to death. Dr. Hindman opined, "Survival might have been possible had the decedent not had the respiratory compromise bought on by these two latter conditions." Dr. Hindman noted in his autopsy summary that the family of the Miner was curious about the presence of black lung disease and the potential benefits which might be available to them. Accordingly, the family requested that no head examination be performed. (D-4).

Dr. Hindman, in an August 10, 1998 letter to the Department of Labor, answered the question of whether or not the Miner had complicated pneumoconiosis as defined by the Act, stating, "Yes, Mr. Klee had classical representation of bilateral coal workers' pneumoconiosis with abundant coal workers' nodules some greater than 1.0 cm. in diameter. In fact, some were greater than 2.0 cm. in diameter." In response to the question as to whether the Miner's death was due to pneumoconiosis pursuant to §718.205, Dr. Hindman responded by repeating the cause of the death he provided to the coroner. Dr. Hindman ended his response by providing a verbatim copy of his conclusions section of the autopsy report. (D-6).

The record contains a copy of the Miner's death certificate, which was filed with the Illinois Department of Public Health at Springfield on May 6, 1998. The Miner died on April 10, 1998 at the age of 74. The Miner's cause of death was a pulmonary thromboembolism to the right lung. Other significant conditions contributing to death but not resulting in the underlying cause of death were bilateral chronic coal workers' pneumoconiosis and pulmonary emphysema. (D-3).

Dr. Richard L. Naeye, board-certified in anatomical and clinical pathology and the Chairmen of the Department of Pathology at Pennsylvania State University College of Medicine, reviewed medical records, pulmonary function studies, employment and smoking histories, the autopsy report summary, and eight glass slides[7] with tissues removed at autopsy and prepared a report dated October 31, 1998. (D-15). Dr. Naeye described findings of many anthracotic macules, two anthracotic micronodules and one macronodule with a mixed fibrous tissue and few thin rims of focal emphysema suggestive of the presence of moderately severe coal workers' pneumoconiosis. He found these findings compatible with chest x-ray findings in recent years. Dr. Naeye found that the only significant abnormality in pulmonary function tests was evidence of small airway obstruction, which he described as an abnormality compatible with the Miner's cigarette smoking history rather than his coal workers' pneumoconiosis. He also found that the Miner had mestastasized lung cancer, and that a large pulmonary arterial embolus was the direct cause of death. Dr. Naeye, citing medical literature in support of his conclusion, found that the Miner's lung cancer was a result of his smoking and not coal mine dust exposure, and, that there was no evidence that the Miner's coal workers' pneumoconiosis caused any significant impairment to lung function or contributed in any way to his death.

Dr. Naeye was deposed on June 15, 2000. (E-6). Dr. Naeye indicated that he was one of the authors of *Pathologic Standards for the Diagnosis of Coal Workers' Pneumoconiosis*, along with Drs. Kleinerman and Wiot. Jerome Kleinerman et al., *Pathology Standards for Coal Workers' Pneumoconiosis*. 103(8) ARCH. PATH. LAB. MED. (Special Issue) 375-432 (1979). He testified that based on his review of the autopsy slides and medical records, the Miner had simple coal workers' pneumoconiosis and not complicated pneumoconiosis (E-6 at 10). Included in his testimony was a description of what evidence would support a finding of complicated pneumoconiosis (also referred to as progressive massive fibrosis) and how that evidence was absent from this case (E-6 at 10-12, 35). Dr. Naeye testified that the 2.0 cm. standard for pathologic diagnosis of complicated pneumoconiosis, which was originally established in 1979, is generally accepted in the pathologic community and has not been superseded by any other standard perpetuated by pathologists (E-6 at 45). Dr. Naeye disagreed with the finding of complicated pneumoconiosis on slides thirteen and ten by Dr. Jones, described below.

Dr. Naeye reiterated his opinion that the Miner's May 1996 pulmonary function study and arterial blood gas study were essentially normal, and that he, therefore, did not believe that the Miner's simple pneumoconiosis played any role in causing or hastening the Miner's death (E-6 at 19-23, 39). Dr. Naeye testified that he did not know why the physicians did not attempt to remove the Miner's lung cancer. However, he listed some factors that might cause a treating physician to decide not to perform surgery when the lung is involved including metastases and the presence of other disease processes in the lungs. (E-6 at 34).

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[7] Dr. Kleinerman described the contents of the eight slides in his consultative report of December 12, 1998. (D-16). Dr. Kleinerman stated that the slides were numbered one through four and ten through thirteen. He stated that slide one was of the pancreas, slide two was of myocardium, slide three was of kidney, slide four was of liver, and that slides ten, eleven, twelve, and thirteen were sections of bronchus, hilar lymph node, pulmonary artery, and lung.

Dr. Jerome Kleinerman, board-certified in pathologic anatomy and clinical pathology, reviewed medical treatment records as set forth in the Appendix of his December 12, 1998 pathology consultation report. (D-16). He also reviewed Dr. Hindman's autopsy report and the eight autopsy slides. Dr. Kleinerman found a history of thirty-six years of active coal mine employment, noted the nature and physical requirements of the Miner's last coal mine employment and reported a smoking history of one to two packs of cigarettes per day for fifty years before quitting in 1982, noting Dr. Braud's smoking history of one pack per day for forty years. Accordingly, Dr. Kleinerman calculated a cumulative smoking history of between forty and one hundred pack years.

Dr. Kleinerman set forth his review of the eight autopsy slides. He noted that the largest mass, which he described as conglomerate of nodules, had a an aggregate measurement of 1.6 cm. in greatest diameter. Dr. Kleinerman opined that the Miner had simple coal workers' pneumoconiosis, but did not have complicated coal workers' pneumoconiosis in light of the size, location and organization of the macules. In further explaining his determination that the Miner did not suffer from complicated pneumoconiosis, Dr. Kleinerman cited the standard pathologic criteria for the diagnosis of complicated coal workers' pneumoconiosis, which are contained in the document *Pathologic Standards for Coal Workers' Pneumoconiosis*. Part of the standard mandates that lesions of complicated coal workers' pneumoconiosis or complicated silicosis must be at least 2.0 cm. in diameter. Accordingly, Dr. Kleinerman reiterated that the histologic slides of the Miner's lungs did not provide evidence of a large solid pigmented hard mass characteristic of complicated coal workers' pneumoconiosis in the lung proper. Dr. Kleinerman further noted that the presence of true complicated pneumoconiosis is usually associated with the presence of severe and progressive obstructive lung disease. In the Miner's case, the 1996 pulmonary function studies failed to provide evidence of such obstructive airways dysfunction or severe and progressive arterial hypoxemia.

Dr. Kleinerman concluded that the Miner had a moderate degree of simple coal workers' pneumoconiosis including one area of conglomerate simple coal workers' pneumoconiosis, but no evidence of the massive lesions seen with complicated pneumoconiosis. He indicated that the Miner's respiratory impairment did not result from his coal mine employment or pneumoconiosis. He found that the Miner was totally and permanently disabled at the time of this death due to his adenocarcinoma of the lung which had metastasized and not as a result of his coal workers' pneumoconiosis. Dr. Kleinerman opined that the Miner's coal workers' pneumoconiosis was not a substantial contributing cause of his death. He further opined that the Miner's lung cancer was due to his long and heavy smoking history and provided citations for his opinion that coal mine dust is not associated with adenocarcinoma.

Dr. Miles J. Jones, board-certified in clinical, anatomical and forensic pathology, reviewed the reports of Drs. Kleinerman, Naeye and Wiot, pathology and radiology reports from the Memorial Medical Center, eight pathology slides dated May 30, 1998 and fourteen pathology slides dated June 3, 1996, a U.S. Department of Labor Workers' Compensation Program Report, and the autopsy report and death certificate prepared by Dr. Hindman in preparing a consultative report dated May 26, 1999. (D-23). Dr. Jones noted over thirty years of coal mine employment and an accumulated smoking history of less than fifty pack years. He found that the pulmonary function studies showed abnormal FEV, and that the arterial blood gases showed less than normal arterial oxygen saturation.

Dr. Jones reviewed the eight autopsy slides. Dr. Jones opined that the Miner suffered from progressive massive fibrosis evidenced by the "extensively hyalinized peribronchial lymph nodes, the large subpleural coal dust macules and the coalescing of extensively hyalinized coal dust macules." He opined that the Miner's emphysema and coal workers' pneumoconiosis significantly weakened his pulmonary function so as to make it impossible to recover from his pulmonary embolus and significantly contributed to his respiratory failure which led to death. Therefore, coal workers' pneumoconiosis played a significant role in the causation and hastening of the Miner's death. Dr. Jones also opined that the Miner's "coal mining related occupational lung diseases hastened his death by reducing his pulmonary reserve and making it impossible for him to receive surgical treatment for his pulmonary cancer and minimizing his chances of surviving a pulmonary embolus." He found that the neither the Miner's cancer or pulmonary embolus were related to his coal mine employment.

Dr. Jones was deposed on April 6, 2000. (E-5). Dr. Jones stated that he found evidence of complicated pneumoconiosis on two of the autopsy slides, ten and thirteen (E-5 at 7-8). He indicated that he did not have any primary medical data on the Miner when he reviewed the slides, but had other physicians' reports. (E-5 at 11-12). Dr. Jones indicated that he did not see any coal dust macules larger than 0.9 cm. (E-5 at 13). He also stated that he utilized the Department of Labor's ILO standard of 1.0 cm. size criterion for progressive massive fibrosis (E-5 at 14). Dr. Jones reiterated his findings that the Miner's coal workers' pneumoconiosis significantly effected and hastened his death (E-5 at 24-26, 29-30, 37, 49).

Dr. P. Raphael Caffrey, board-certified in anatomical and clinical pathology, reviewed medical treatment records, consultative reports, and autopsy materials, including the eight autopsy slides as listed on the first two pages of his November 8, 1999 report. (E-2). Additionally, Dr. Caffrey considered a work history of thirty-six to thirty-eight years in underground coal mining and a smoking history of forty to fifty years. Dr. Caffrey diagnosed the Miner with moderately differentiated adenocarcinoma of the left lung, moderately severe simple coal workers' pneumoconiosis with nodular coal workers' pneumoconiosis , hyalinized micronodules in hilar lymph nodes, focal, acute bronchopneumonia of the right lung and centrilobular emphysema. He also noted mild to moderate fatty metamorphosis of the liver.

Dr. Caffrey opined that the Miner suffered from moderately severe simple coal workers' pneumoconiosis with no evidence of massive fibrosis or complicated pneumoconiosis. He specifically disagreed with Dr. Jones's finding of complicated pneumoconiosis, noting that the proper pathologically diagnostic standard for lesions of complicated pneumoconiosis/progressive massive fibrosis, as set out in the 1979 publication *Pathologic Standards for Coal Workers' Pneumoconiosis,* is a lesion "at least 2 cms in diameter." Dr. Caffrey also opined that coal mine dust had no causitive relationship to the Miner's lung carcinoma or emphysema. He disagreed with Dr. Jones's finding that extensive damage to the Miner's lungs by coal workers' pneumoconiosis significantly reduced his chances of surviving pulmonary cancer by denying him the opportunity to have the most effective treatment, surgery, and allowed the cancer to progress and predispose him to fatal embolus. Dr. Caffrey explained that the medical records indicated that the Miner was treated with chemotherapy instead of surgery because the lesion in the right lung was highly

suspicious for another carcinoma. Dr. Caffrey found no pulmonary impairment due to pneumoconiosis based on pulmonary function and arterial blood gas studies, which showed mild abnormalities due to cigarette smoking. Dr. Caffrey concluded that the Miner's coal workers' pneumoconiosis did not cause, substantially contribute to or hasten his death.

Dr. Caffrey was deposed on July 10, 2000. (E-8). Dr. Caffrey reiterated that the 1979 monograph *Pathologic Standards for the Diagnosis of Coal Workers' Pneumoconiosis* sets forth generally agreed upon standard for the diagnosis of coal workers' pneumoconiosis, and added that those standards have not been superseded (E-8 at 10). Dr. Caffrey provided two reasons for how and why he ruled out the presence of complicated pneumoconiosis. Dr. Caffrey reiterated his previous opinions regarding the pulmonary function studies and the cause of the Miner's death. Dr. Caffrey also reiterated his opinion that the Miner did not receive surgery as treatment for his carcinoma because the medical records indicate that is was thought that the miner had bilateral pulmonary cancer and/or more than one cancerous areas involved in the left lung (E-8 at 32).

Dr. Jerome Wiot, board-certified radiologist, NIOSH certified B-reader, and Professor of Radiology at the University of Cincinnati, reviewed six chest x-rays and two CT scan films of the Miner. (D-15, 25). In his June 30, 1999 report, Dr. Wiot indicated that he reviewed the pathology reports in addition to the radiographic evidence. He found that the large opacities he noted on the chest x-rays were not due to coal workers' pneumoconiosis because their size decreased between April and June of 1997, and the pathology reports identified the presence of carcinoma in the lung. He indicated that the chemotherapy for the malignancy resulted in the reduction in the nodular densities on the x-rays. The chest x-rays and CT scans showed evidence of small nodules consistent with simple coal workers' pneumoconiosis involving the upper and mid lung zones. He found no evidence of massive lesions due to coal workers' pneumoconiosis.

Dr. Wiot was deposed on June 23, 2000. (E-7). Dr. Wiot testified that he performed research on pneumoconiosis and worked with Drs. Kleinerman and Naeye as the radiologist to coordinate findings on pathology evidence with those on radiographic presentation for pneumoconiosis. That research resulted in the monograph *Pathologic Standards for Diagnosis of Coal Workers' Pneumoconiosis* (E-7 at 10-11). Dr. Wiot testified that there is an equivalency between the size of an opacity that you see on the chest x-ray and the nodules seen in the lung tissue under a microscope, and that the correlation with respect to complicated pneumoconiosis or massive fibrosis is for a nodule of approximately two cms. identified by a pathologist to cast a one cm. shadow under the ILO x-ray standard (E-7 at 11-12). Dr. Wiot explained that the radiographic evidence he reviewed established the existence of simple coal workers' pneumoconiosis and an "A" sized opacity which he was unable to characterize on the chest x-ray. He needed to see a CT scan to determine whether the opacity was cancer or pneumoconiosis. He indicated that based on the CT scan evidence, there was no massive fibrosis due to pneumoconiosis and that the lesion was cancer. He testified that the Miner had cancer in both lungs in 1996 based on the chest x-ray and CT scans, and that the cancer was bilateral in at least three sites. (E-7 at 17-23). Dr. Wiot indicated that it was essential to have serial chest films and CT scans to make the determination between lesions of cancer and pneumoconiosis in this Miner because by looking at a series of films, he could see that the large opacities

were not pneumoconiosis, but cancer responding to chemotherapy. He noted that in the 1997 chest x-rays, there was a reduction in a density over the third rib between April and June of 1997. He stated that large opacities due to pneumoconiosis do not disappear, but if the Miner had been receiving chemotherapy for his malignancy, those nodules could decrease or disappear. (E-7 at 23)

Dr. Peter G. Tuteur, board-certified in internal medicine and the subspecialty of pulmonary disease, reviewed the medical reports and evidence listed on page one of his December 6, 1999 report. (E-3). Dr. Tuteur noted nearly four decades of underground coal mining and a smoking history of between forty and fifty years at a rate of one and two packages of cigarettes per day. He noted that the medical records were silent with respect to the Miner's health prior to1996. Based on radiographic evidence, Dr. Tuteur concluded that the Miner did have simple coal workers' pneumoconiosis. Based on review of the x-rays and pathology reports, he concluded that the left and right upper lung field nodular densities were caused by adenocarcinoma of the lung and not by massive fibrosis due to pneumoconiosis.

Dr. Tuteur indicated that pneumoconiosis did not cause any significant pulmonary impairment in the Miner based on the pulmonary function studies and arterial blood gases of record, which he noted produced normal results. Dr. Tuteur concluded that the Miner was not totally disabled due to any coal mine dust induced disease, and that his death was not caused or hastened by coal workers' pneumoconiosis or a complication thereof. He noted that the Miner did not have progressive massive fibrosis, but had simple coal workers' pneumoconiosis associated with his nearly normal pulmonary function. Dr. Tuteur concluded that the Miner's death resulted from bilateral, unresectable, widely metastatic adenocarcinoma of the lung associated terminally with pulmonary thromboembolism, and that coal workers' pneumoconiosis neither caused, nor contributed to, nor hastened the Miner's death. Dr. Tuteur opined, based on biopsy evidence and medical records that, "Because of the bilaterality of the masses, he [the Miner] was appropriately considered unresectable."

Dr. Tuteur was deposed on July 24, 2000. (E-9). Dr. Tuteur explained why no surgery was performed on the Miner in 1996. He also explained the several factors which led him to opine that the Miner had simple as opposed to complicated coal workers' pneumoconiosis. Dr. Tuteur confirmed that one of the causes of the Miner's death was a pulmonary thromboembolism (E-9 at 15). He explained that people with cancer have a very high incidence of pulmonary embolism and that there is no relationship between pulmonary embolism and pneumoconiosis (E-9 at 16 and 18). Dr. Tutuer reiterated his previous opinion that the Miner's pneumoconiosis or complication thereof did not cause or hasten his death (E-9 at 18-20). Dr. Tuteur testified that the generally accepted size criteria for pathological progressive massive fibrosis is equal to or greater than 2.0 cm. (E-9 at 38).

Dr. Joseph J. Renn III, board-certified in internal medicine and the subspecialty of pulmonary diseases and NIOSH certified B-reader, reviewed four chest x-rays and two sets of CT scans taken of the Miner along with medical records and consultative reports set forth on the first two pages of his January 5, 2000 consultative report. (E-4). From the documents reviewed, Dr. Renn summarized the Miner's background, cardiopulmonary, occupational, tobacco, past medical and family histories. Dr. Renn reviewed pulmonary function studies showing a mild ventilatory defect. He found that the arterial blood gas studies

were within normal limits. Dr. Renn reviewed four chest x-rays and two sets of CT scans and found evidence of category 1/1 pneumoconiosis, but not massive lesions due to pneumoconiosis. Dr. Renn concluded that neither the Miner's pulmonary emphysema nor his simple coal workers' pneumoconiosis was a significant contributing factor to his demise.

Dr. Renn was deposed on October 5, 2000. (E-10). Dr. Renn described the radiographic appearance of complicated and simple pneumoconiosis, and explained how he observed simple pneumoconiosis in the Miner (E-10 at 10-11). He indicated that the Miner's death was caused by thromboemboli, explaining how a thromboembolus typically causes death. Dr. Renn further explained that a thromboembolus is not a lung disease, but that persons with malignancies are more prone to have them. He stated that coal mine dust does not increase a person's susceptibility to thromboembolus. (E-10 at 13-14). Dr. Renn confirmed that the criteria for a diagnosis of pneumoconiosis causing massive lesions is 2.0 cm. on pathology slides and 1.0 on ILO classifications for chest x-rays (E-10 at 21). Dr. Renn explained that the Miner had sufficient pulmonary reserve to undergo surgery in 1996, but, that his reading of Dr. Braud's treatment notes indicated that the Miner was not a surgical candidate because he had cancer in both lungs (E-10 at 23-24, 37).

Dr. Renn testified that three of the four x-rays he reviewed were copies. He indicated that the original films are supposed to be read if available, noting that it is best to read the originals, and that it is a requirement if one is reading the films for NIOSH. Dr. Renn further explained that, pragmatically, when doing forensic work, one only has a copy of the films, and, therefore, one must determine whether the film copies are of such quality that they can be interpreted for pneumoconiosis. (E-10 at 28-29). Dr. Renn stated that all of the films he had were of readable quality –quality 2. He thought that the three copies were as good in quality as the original film, which was also quality 2. Dr. Renn stated that these films were some of the best copies that he had ever seen. (E-10 at 55-56).

Further Findings of Fact, Conclusions of Law, and Discussion

Benefits are provided to eligible survivors of a miner whose death was due to pneumoconiosis. §718.205(a). In order to receive benefits, the claimant must prove that: (1) the miner had pneumoconiosis; (2) the miner's pneumoconiosis arose, at least in part, out of his coal mine employment; and (3) the miner's death was due to pneumoconiosis as provided by the applicable part of §718.205. §718.205(a). At the hearing, Employer stipulated to the existence of simple coal workers' pneumoconiosis arising out of the Miner's coal mine employment (Tr. 14). Because this claim was filed subsequent to January 1, 1982, death will be considered due to pneumoconiosis if any of the following criteria is met: 1) where competent medical evidence establishes that pneumoconiosis was the cause of the miner's death; 2) where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where death was caused by complications of pneumoconiosis; or 3) where the presumption set forth at §718.304 is applicable. §718.205(c). Survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death. *Id.* Pneumoconiosis is a "substantially contributing cause" of the miner's death if it hastens the miner's death.

Id.

Death Due to Pneumoconiosis

§718.205(c)(1)–Pneumoconiosis was Not the Cause of Death

The evidence of record clearly establishes that the Miner's death was not directly caused by his pneumoconiosis. The Miner's death certificate indicates that death resulted immediately from pulmonary thromboembolism to the right lung (D-3). Dr. Hindman, acting as the coroner, listed the same in his autopsy report of May 2, 1998, explaining that the thromboembolus resulted in a high grade obstruction of the blood flow to the right lung, and noting that there were no thromboemboli in the left lung (D-4). Every physician rendering an opinion in this case agreed with this conclusion. Drs. Caffrey and Renn explained that pulmonary embolism is not properly referred to as a respiratory disease (E-8 at 31; E-10 at 14). Instead, Dr. Caffrey explained that pulmonary emboli are existent within lung parenchyma, and because they are emboli, they are secondary or metastatic, meaning that they originate in another part of the body and travel to the lungs (E-8 at 31; see also E-9 at 16-19; E-10 at 13-14). Dr. Jones explained, and Dr. Caffrey agreed that, "pulmonary embolisms are massive, sudden events that can be, and often are life-ending." (E-5 at 37; E-8 at 32). While none of the physicians related pulmonary emboli to pneumoconiosis or coal mine employment, Drs. Naeye, Renn, and Tuteur pointed out that people with cancer tend to have a high incidence of pulmonary embolism (E-6 at 38; E-9 at 16; E-10 at 14). All physicians agreed that the Miner had lung cancer that had metastasized to his brain. (See D-14 at 93-94). Therefore, the preponderance of the evidence establishes that the Miner's direct cause of death was pulmonary embolism, which was unrelated to his pneumoconiosis, and probably associated with his lung cancer.

§718.205(c)(2)–Pneumoconiosis was Not a Substantially Contributing Cause or Factor Leading to the Miner's Death, and Death was Not Caused by Complications of Pneumoconiosis

The preponderance of the evidence does not establish that the Miner's pneumoconiosis hastened the Miner's death, or that his death was caused by a complication related to pneumoconiosis. Claimant asserts that the evidence supports two manners in which the Miner's pneumoconiosis hastened his death. First, at the hearing, Claimant proposed that the evidence suggests that the Miner's pneumoconiosis caused a respiratory disease that was present at the time his cancer was diagnosed, and that his physicians chose a less aggressive treatment of the cancer than surgical resectioning of the lung because of the existence of that pneumoconiotic induced lung disease (Tr. 15). Second, in her post hearing brief, Claimant asserted, based on the opinions of Drs. Hindman and Jones, that the existence of the Miner's coal dust induced disease played an additive role with his lung cancer, weakening and progressively destroying his respiratory function such that his chances of surviving the pulmonary embolism were minimized. Claimant's Post Hearing Brief at 53. While the two physicians' opinions and the lay testimony of the Claimant and two daughters tends to support these arguments, the overwhelming preponderance of the more credible evidence indicates otherwise.

The record establishes that three physicians treated the Miner during his bout with cancer, Drs. Mayer, Gumprecht and Braud. The related medical records appear to be complete and contained within the record (see D-14, 29). In their respective reports, none of these physicians referred to the Miner's pneumoconiosis or coal mining employment as a contributing factor to his lung cancer and other health problems. In fact, none of these physicians recorded that the Miner suffered from pneumoconiosis in any capacity. Upon review of the copious treatment records, only one physician speculated as to whether the Miner had pneumoconiosis. Dr. Kozloff, an internist who provided a one-time examination of the Miner for his insurance company as a second opinion to that of Dr. Braud regarding his cancer diagnosis, stated in a two sentence letter dated July 23, 1996, that "He [the Miner] has non small cell lung cancer, chronic lung disease, and his chest x-ray is suggestive of pneumoconiosis." (D-29 at 21). Not only did Dr. Kozloff fail to provide a reasoned opinion as to whether or not the Miner definitively had either legal or clinical pneumoconiosis, but he did not provide an opinion regarding the treatment of the Miner's cancer or how pneumoconiosis could affect such treatment. Accordingly, the medical records do not indicate that the physicians treating the Miner's cancer even contemplated a diagnosis of pneumoconiosis in their consideration of his treatment and prognosis.

Dr. Braud, the internist specializing in medical oncology, consulted repeatedly with the Miner and his family regarding the treatment of his lung cancer, but did not refer to pneumoconiosis in his treatment notes under past medical history or pursuant to physical examination, and indicated that the Miner's lung fields were clear with generalized decreased breath sounds (D-29 at 27). For follow-up consultation, Dr. Braud's treatment notes carried a diagnosis of "Lung carcinoma with apparent synchronous primaries," but his explanation as to why the Miner was not a surgical candidate was not clearly stated due to an ambiguous reference to the Miner's "lung disease." (D-29 at 26). The question for all the consulting physicians in this case was, therefore, "Which of the Miner's lung diseases prevented him from being a surgical candidate?" Based on the preponderance of the evidence relevant to deciphering Dr. Braud's decision not to recommend surgery due to an unidentified "lung disease," this tribunal now finds that pneumoconiosis was not the "lung disease" in question. The reasoned medical opinions of record persuasively indicate that the Miner was not considered a surgical candidate because he had primary tumors of lung cancer in both lungs or that his lung cancer had metastasized, or both.

Most persuasive to this tribunal was Dr. Braud's treatment note dated August 5, 1996, wherein Dr. Braud again implied that surgery was not an option, stating, "He [the Miner] was recently diagnosed to have unresectable carcinoma based on the fact that he had apparent synchronous primaries." (D-29 at 25).[8] Dr. Braud's decision to rule out surgery was supported by the opinions of Drs. Naeye, Caffrey, Tuteur and

[8] According to Merriam-Webster's Collegiate Dictionary, "synchronous" means happening, existing, or arising at precisely the same time, period, and/or phase. According to the MedTerms Dictionary, a "primary" tumor is one that is at the original site at which it arose. These definitions, by their nature, may properly be deemed subject to judicial notice.

Renn, who all reviewed both the Miner's treatment notes and extensive medical evidence for this case.[9] Dr. Naeye testified that while he did not know why surgery was not performed on this miner, he stated that a common reason for avoiding surgery would be metastases in other organs, noting the brain as a common place for metastases (E-6 at 34). Dr. Caffrey opined, based on the medical records and x-ray findings, that the Miner was treated with chemotherapy instead of surgery because it was thought that the Miner had bilateral pulmonary cancer and that more than one area was involved in the left lung. (E-2; E-8 at 32). Dr. Caffrey explained that patients with bilateral carcinoma are never considered candidates for surgery (E-8 at 32). Based on biopsy and medical evidence, Dr. Tuteur also opined that the Miner was appropriately considered unresectable due to the bilaterality of the masses in his lungs (E-3). Accordingly, this tribunal finds that the preponderance of the evidence indicates that Claimant's pneumoconiosis did not prevent him from having surgery or hasten the Miner's death by preventing him from undergoing a lung resection,and that the biopsy and x-ray evidence as interpreted by most physicians indicates that the Miner's cancer, which was thought to have spread to either or both his right lung and other areas of his left lung, precluded treatment by surgical intervention.

Only one physician, Dr. Jones, believed that the Miner's pneumoconiosis hastened his death by precluding surgical intervention. Dr. Jones's opinion is unpersuasive because it is manifestly inconsistent with the evidence of record. While Dr. Jones did not review the Miner's medical records, including Dr. Braud's treatment notes, he did review the consultative reports of Drs. Naeye and Kleinerman, who, based on review of the Miner's pulmonary function and arterial blood gas studies, found the Miner's lung function to be essentially normal eight years after the Miner left the coal mines (D-15, 16; E-6 at 19-23, 19).[10] Nevertheless, Dr. Jones opined in his consultative report that the Miner's "coal mining related occupational lung diseases hastened his death by reducing his pulmonary reserve and making it impossible for him to receive surgical treatment for his pulmonary cancer and minimizing his chances of surviving a pulmonary embolus." (D-23). He did not find that the Miner's cancer or pulmonary embolus were related to his coal mine employment. Accordingly, Dr. Jones's finding of a reduced pulmonary reserve is unpersuasive, and his opinion based thereon, is unpersuasive. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (*en banc*).[11]

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[9] This tribunal is unpersuaded by the lay hearsay testimony of the Claimant and her daughters that during a June 1996 meeting with Dr. Braud, Dr. Braud stated that the Miner's cancer was inoperable because he had silicosis in his lung (Tr. 23, 30, 32, 39). The record is otherwise devoid of evidence that Dr. Braud believed that the Miner had pneumoconiosis or that it affected his assessment; nor did he include in his treatment notes a discussion of pneumoconiosis with the Miner and his family at the June 1996 meeting. Because the lay testimony of the Miner's family members is uncorroborated by the medical evidence, it is not entitled to significant weight. *See Cooper v. United States Steel Corp.*, 7 B.L.R. 1-842 (1985).

[10] Dr. Kleinerman also noted in his report that the Miner's pulmonary function studies failed to provide evidence of severe and progressive obstructive airways dysfunction or severe and progressive arterial hypoxemia associated with the presence of true complicated pneumoconiosis (D-16).

[11] During his deposition, Dr. Jones also opined that surgical treatment was not considered viable, "possibly" because the Miner's lungs were sufficiently damaged by prior existing coal workers' pneumoconiosis (E-

The preponderance of the evidence also does not establish that the Miner's pneumoconiosis played an additive role with his lung cancer by weakening and progressively destroying his respiratory function such that his chances of surviving the pulmonary embolism were minimized. Only two physicians, Drs. Hindman and Jones, opined that the Miner's pneumoconiosis contributed to or hastened his death. Dr. Hindman performed the autopsy on the Miner, and in his report stated ambiguously that survival might have been possible had the Miner not had the respiratory compromise brought about by his severe bilateral coal workers' pneumoconiosis and bilateral pulmonary emphysema (D-4).[12] It is unclear whether he referred to ultimate survival or a more extended period of demise; neither is persuasively demonstrated. Additionally, Dr. Hindman's conclusion is unaccompanied by explanation or analysis. He did not list or describe evidence such as pulmonary function or arterial blood gas studies in support of his conclusion that the Miner's respiratory system was compromised by either his pneumoconiosis or emphysema. His conclusion is not consistent with the other credible evidence, which is to the contrary. Hastening will be found where there is an "actual or real share in producing an effect." *Peabody Coal Co. v. Director, OWCP (Railey)*, 972 F.2d 178, 183 (7th Cir. 1992). Dr. Hindman only opined that the Miner "might" have survived had he not had coal workers' pneumoconiosis or emphysema. Dr. Hindman's speculative conclusion is ambiguous as to whether the Miner would have actually survived absent his pneumoconiosis. Accordingly. Dr. Hindman's opinion does not resolve the issue of hastening. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (*en banc*); *Island Creel Coal Co. v. Holdman*, 202 F.3d 873 (6th Cir. 2000).

Dr. Jones's opinion on this theory of causation is also unpersuasive. Towards the end of his deposition, Dr. Jones explained the mechanism that he found linked the Miner's pneumoconiosis, which he identified as progressive massive fibrosis, to his death, stating:

> There are three primary factors causally related to Mr. Klee's death, and it's the pulmonary embolism, the coal workers' pneumoconiosis, and the presence of adenocarcinoma, and they are all interrelated and intermingled.
>
> **For instance**, a decrease in blood flow due to inactivity **can be** a causal cause of development of emboli. With decreased oxygenation, Mr. Klee was less active, and therefore it **could precipitate** the pulmonary embolus.
>
> The **cancer can produce** a hypercoaglable state, a state that you're more likely to develop an embolus. And the lack of very strong lungs, that his lungs have been damaged by years of coal mining **can** reduce your chances

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5 at 28-30). This speculative statement is equivocal and of no probative value. *Knitzer v. Bethlehem Mines Corp.*, 8 B.L.R. 1-5 (1985);

[12] When provided with a copy of §718.205 by the Department of Labor and asked whether the Miner's death was due to pneumoconiosis, Dr. Hindman simple repeated, verbatim, his autopsy conclusions (D-6).

> or surviving a pulmonary embolus.
>
> So all three were interrelated, and therefore, coal workers' pneumoconiosis was causally related, and **did** play a significant part in hastening Mr. Klee's death. (E-5 at 59) (emphasis added).

Dr. Jones reasoned by induction that the Miner's pneumoconiosis actually affected his death. In doing so, Dr. Jones largely ignored the objective evidence, instead, focusing his attention on the ultimate conclusion that pneumoconiosis hastened the Miner's death. Since Dr. Jones's analysis depends upon hypothetical generalities, it does not support his unequivocal conclusion that pneumoconiosis hastened the Miner's death. Thus, Dr. Jones's opinion is unpersuasive because it is speculative and unsupported by the objective evidence of this case.

Since none of the other physicians of record opined that the Miner's pneumoconiosis caused or hastened his death in any way; since the well-reasoned opinions of several physicians that the Miner did not suffer from a respiratory impairment associated with pneumoconiosis; and since they concluded there is a lack of evidence that the Miner was in a compromised condition caused by pneumoconiosis such that he was physiologically unable to withstand the pulmonary embolus, or that the embolus was caused by his pneumoconiosis, this tribunal finds that the Miner's death was not hastened by his pneumoconiosis. Pneumoconiosis neither contributed to the Miner's death by prevented him from receiving surgical treatment for his cancer nor hastened his death by causing his life-ending pulmonary embolism or weakening his ability to withstand it.

§718.205(c)(3)–Applicability of the Presumption Set Forth at §718.304

Section 718.304 provides an irrebuttable presumption that the miner is totally disabled by or that the miner's death was due to pneumoconiosis if the miner is suffering or suffered from a chronic dust disease of the lungs of an advanced degree frequently referred to as complicated pneumoconiosis. *See Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 7, 11 (1996); *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F.3d 250, 255 (4th Cir. 2000). Section 718.304 sets out three manners in which a claimant may establish the existence of complicated pneumoconiosis: a) diagnosis by x-ray yielding one or more large opacities classified in Category A, B, or C in the International Classification of Radiographs of the Pneumoconioses by the International Labor Organization; b) diagnosis by biopsy or autopsy yielding massive lesions in the lungs, or c) when diagnosis by means other than those specified by (a) and (b) would be a condition which could reasonably be expected to yield the results described in paragraph (a) or (b) had diagnosis been made as therein described. Any diagnosis made under paragraph (c) must accord with acceptable medical procedures. §718.304(c). The Benefits Review Board has held that §718.304(a)-(c) do not provide alternative means of establishing the irrebuttable presumption of total disability due to pneumoconiosis, but rather require the administrative law judge to first evaluate the evidence in each category, and then to weigh together the categories at §718.304(a)-(c) prior to invocation. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991) (*en banc*); *see also Dennis E. Keene v. G & A Coal Co.*, BRB No. 96-1689 BLA-A (September 27, 1996) (*unpublished*).

The United States Court of Appeals for the Seventh Circuit does not appear to have a decision on point construing §718.304 in a survivor's claim. However, in recent decisions, several other Circuit Courts have construed this section and provided additional guidance for analysis consistent with the terms and intent of the section. In the most recent decision on point, the Fourth Circuit in *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro),* 220 F.3d 250 (4th Cir. 2000), affirmed its position in *Double B Mining Inc. v. Blankenship,* 177 F.3d 240 (4th Cir. 1999) and adopted the Third Circuit's holding in *Clites v. Jones & Laughlin Steel Corp.*, 663 F.2d 14 (3d Cir. 1981), that the three prongs of §718.304 are intended to describe a single, objective condition. *Id*. at 255. Accordingly, as each prong requires a separate analysis, the Court held, "one must perform equivalency determinations to make certain that regardless of which diagnostic technique is used, the same underlying condition triggers the irrebuttable presumption." *Scarbro at 255-256; Blankenship* at 243; *see also Jones Laughlin Steel Corp.* at 16.

In *Blankenship*, the Fourth Circuit elaborated the required equivalency determination, stating:

> Because prong (A) sets up an entirely objective scientific standard, it provides the mechanism for determining equivalencies under prong (B) or prong (C). In prong (A), Congress mandated that the condition that triggers the irrebuttable presumption is one that creates, on an x-ray, at least one opacity greater than one centimeter in diameter. When that condition is diagnosed by biopsy rather than x-ray, it must therefore be determined whether the biopsy results show a condition that would produce opacities of greater than one centimeter in diameter on an x-ray. That is to say, "massive lesions," as described in prong (B), are lesions that when x-rayed, show as opacities greater than one centimeter in diameter.

Blankenship at 243. The Court recognized that it might be necessary for an ALJ to make a separate equivalency determination each time a miner presents evidence of massive lesions diagnosed by biopsy. *Id.* at 244. The Court stated that "the x-ray evidence can lose force only if other evidence affirmatively shows that the opacities are not there or are not what they appear to be perhaps because of an intervening pathology, some technical problem with the equipment used, or incompetence of the reader." *Scarbro* at 256.

The Sixth Circuit's analysis under §718.304 is in accord with the Fourth Circuit's. In *Gray v. SLC Coal Co.*, 176 F.3d 382 (6th Cir. 1999), the Court noted that x-ray evidence of opacities measuring at least one centimeter does not, alone, trigger the irrebuttable presumption where conflicting autopsy evidence exists, and that the "one-centimeter standard applicable to x-rays simply does not apply to autopsy evidence." In noting that "all relevant evidence" must be weighed prior to invocation of the presumption, the Court declared, "The irrebuttable presumption does not apply until the presence of a chronic dust disease is established by evidence satisfactory to the ALJ." *Id.* at 388-390. *See Lester v. Director, OWCP*, 993 F.2d 1143, 1144-1145 (4th Cir. 1993) (Congress intended "to grant to the miner an irrebuttable presumption not because he has provided a single piece of relevant evidence, but because he has a 'chronic dust disease of the lung,' commonly known as complicated pneumoconiosis."). Since the

record of this claim contains evidence under each of the three prongs under §718.304, this tribunal must make an equivalency determination with respect to prongs (b) and (c).

X-ray Evidence under Prong (a) of §718.304

The record contains evidence of twelve chest x-rays reviewed by nine physicians for a total of thirty-five x-ray interpretations. Of those nine physicians, five were board-certified radiologists, two were B-readers, and two were dually qualified board-certified radiologists and B-readers. Prong (a) of §718.304 dictates that the presumption is established by x-rays yielding one or more large opacities greater than 1.0 centimeter in diameter that would be classified in Category A, B or C in the ILO-U/C International Classification of Radiographs of the Pneumoconioses. Of the nine physicians, only Dr. Alexander interpreted the films as positive for complicated pneumoconiosis, Category A.

However, Dr. Wiot, a dually qualified board-certified radiologist and B-reader, initially reviewed four x-rays and identified large opacities, which he classified as category A strictly for purposes of complying with the ILO standards (D-15, 25). Dr. Wiot summarized his findings for these four films by explaining that it was impossible for him to make a final determination as to the presence of absence of coal workers' pneumoconiosis based on the x-rays alone, and suggesting that clinical information and a CT scan would be of benefit in evaluating the patient. On July 30, 1999, Dr. Wiot reviewed two additional films, but did not identify any large opacities in these x-rays, and instead found that the Miner had cancer.

Dr. Renn, who is a B-reader, and to a lesser extent Dr. Gaziano, who is also a B-reader, provided reports supportive of Dr. Wiot's opinion. Dr. Renn, like Dr. Wiot, reviewed CT scans and other pathological evidence in addition to x-ray films. (E-4). While Dr. Renn identified a right upper lung lesion measuring 1.5 x .8 cm. in each of the x-rays, he did not classify it as a large opacity, and instead, determined that it was likely of an inflammatory etiology. He also noted cancer in the left upper lung. During his October 5, 2000 deposition, Dr. Renn explained that he did not classify the large masses as opacities of progressive massive fibrosis because one was a malignancy, and the other was an inflammatory reaction which was not consistent with a lesion of progressive massive fibrosis (E-10 at 10-11). He explained that a progressive massive fibrosis lesion appears either ill-defined or uniform, but most often uniform and has traction emphysema (E-10 at 11).

Dr. Gaziano reviewed six films for this case. He reviewed the May26, 1996 film, and found no large opacities (D-29). Dr. Gaziano reviewed the films of May 30, May 31, June 3, June 4, and August 5, 1996 as a series, twice, once on October 14, 1996 and again on December 19, 1996. During his first review of the films, Dr. Gaziano noted a large Category A opacity in all the films except for the June 4 film (D-29). However, during his second review, Dr. Gaziano did not note any large opacities, and instead noted the existence of cancer (D-29). Dr. Gaziano did not provide a written report of his findings, and did not explain why he no longer found large opacities on this second review of the films. While Dr. Gaziano's ultimate conclusion was that the Miner did not have complicated pneumoconiosis, his reports are internally inconsistent and his opinion based thereon is equivocal. *See Hopton v. U.S. Steel Corp.,* 7 B.L.R. 1-12 (1984).

Drs. Williams, Cull and Ambrosini, all board-certified radiologists, reviewed several of the Miner's x-rays in connection with the treatment of his cancer. (D-14, 29). While these physicians all identified opacities greater than or equal to 1.0 cm. in diameter, none attributed those nodules to any disease process associated with pneumoconiosis, progressive massive fibrosis or coal dust exposure. Nor did any utilize the ILO classification of radiographs for pneumoconioses. It appears that these physicians were only noting the progression of the Miner's cancer and his reactions and responses to treatment. Accordingly, their reports are not probative under prong (a) of §718.304.

The opinions of Drs. Wiot, Renn and Gaziano together outweigh that of Dr. Alexander, who recognized the need for corroborative support for his x-ray interpretations and was not shown to have received it. Accordingly, because all but one of the physicians ultimately determined that the Miner did not have one or more opacities classifiable as large opacities under the applied ILO system, this tribunal finds that the Claimant has not established the existence of complicated pneumoconiosis by the preponderance of x-ray evidence under prong (a).

Biopsy and/or Autopsy Evidence under Prong (b)

The record contains evidence of three biopsies and one autopsy. In addition to the prosecting pathologist, Dr. Hindman, four pathologists reviewed either or both the autopsy report and accompanying set of eight slides.

Prong (b) of §718.304 provides that the irrebuttable presumption may be established by diagnosis of a chronic dust disease of the lung via biopsy or autopsy yielding massive lesions in the lung. Under pathologic criteria for a "massive lesion," the condition(s) diagnosed pathologically must indicate a condition that would produce opacities of greater than one centimeter in diameter on an x-ray. *Double B Mining Inc. v. Blankenship*, 177 F.3d 240, 243 (4th Cir 1999). In this case, Drs. Kleinerman, Naeye, Caffrey, Wiot, Tuteur, and Renn agreed that the 2.0 cm. standard minimum diameter for a lesion of complicated pneumoconiosis established by the Pneumoconiosis Committee of the College of American Pathologists in *Pathology Standards for Coal Workers' Pneumoconiosis* in 1979 remains the generally agreed upon standard in the pathologic community for the pathologic diagnosis of complicated coal workers' pneumoconiosis (D-16; E-6 at 6, 45; E-7 at 11, 36; E-8 at 10; E-9 at 38; E-10 at 21, 42).

Dr. Jones disagreed with the 2.0 cm. pathologic standard for diagnosing complicated pneumoconiosis because he contends that x-rays and CT scans have improved such that "when they [radiologists] can see it at 1 centimeter, basically we [pathologists] can diagnose it pathologically at 1 centimeter." (E-5 at 16). Dr. Wiot disagreed with Dr. Jones's reasoning, stating that while CT scans have improved in quality since the 1970s, chest x-rays have not (E-7 at 38). Moreover in *Gray v. SLC Coal Co.*, 176 F.3d 382, 390 (6th Cir. 1999), the Court, citing *Riddle v. Director, OWCP*, 1995 WL 715303 (4th Cir. 1995) (*per curiam),* stated, "The one-centimeter standard applicable to x-rays simply does not apply to autopsy evidence." This tribunal, therefore, finds that the preponderance of the evidence supports a finding that the 2.0 cm. pathologic standard is equivalent to the 1.0 cm. ILO radiographic standard for diagnosis of complicated pneumoconiosis, as opposed to the standard adopted by Dr. Jones

Of the three biopsies performed on the Miner in 1996, none identified lesions of pneumoconiosis; all either identified cancer or lesions suspicious for cancer (D-14, 29). However, in an August 10, 1998 letter to the Department of Labor, the autopsy prosector, Dr. Hindman, opined that the Miner had complicated pneumoconiosis as defined in §718.304, finding that the Miner had abundant nodules of coal workers' pneumoconiosis, some greater that 2.0 cm. in diameter. (D-6). Dr. Hindman's report did not provide a gross or microscopic analysis of the lung tissue, but he identified the existence of at least one massive lesion that was at least 2.0 cm. in diameter, which under the applicable standard would presumably produce at least a 1.0 cm. opacity on x-ray.

On the other hand, though Dr. Jones, the pathologist, diagnosed the Miner with complicated pneumoconiosis, he did not identify any massive lesions of at least 2.0 cm. in diameter. He opined that progressive massive fibrosis and complicated pneumoconiosis were essentially the same, except that complicate pneumoconiosis is a statutory designation. Based on his review of the autopsy slides, Dr. Jones found that the sections of lung tissue reviewed diagnostically confirmed a diagnosis of coal workers' pneumoconiosis and progressive massive fibrosis. (D-23). Dr. Jones described "Multiple collections of cells with fibrous centers and peripheral margins containing pigment-filled histiocytes ("classical") coal dust macules measuring as least 0.05 cm.. to 0.9 cm. in maximal dimension," upon which he based a diagnosis of massive aggressive pulmonary fibrosis, applying, contrary to the accepted standard, the one cm. standard to lesions which he opined were only partially preserved on the slides (E-5 at 13-14).[13] Nevertheless, Dr. Jones's opinion fails to support a finding of complicated pneumoconiosis in this case for several reasons. First, he utilized a 1.0 cm. pathological standard, whereas this tribunal has determined that a 2.0 cm. standard is appropriate for ensuring equivalency within the three prongs of §718.304. Second, he did not identify the existence of a single macule that met his own 1.0 cm. standard. Third, his diagnosis of progressive massive fibrosis in the Miner is not necessarily the equivalent of a diagnosis of statutory complicated pneumoconiosis in this case, because his diagnosis of progressive massive fibrosis depends upon his identification of coalescing macules that he assumed continued off the slide and formed a lesion that was at least 1.0 cm. in diameter, but not at least 2.0 cm.. There is no evidence that such progression occurred.

The other well qualified pathologists who reviewed the slides and relevant autopsy materials, Drs. Kleinerman, Naeye and Caffrey, all agreed that the Miner did not suffer from pathologic complicated pneumoconiosis. Utilizing the size, location, organization and microscopic appearance of the Miner's pneumoconiosis macules, these physicians opined based on the autopsy slides that the Miner had simple but not complicated pneumoconiosis. Drs. Kleinerman and Naeye also ruled out complicated pneumoconiosis with evidence that the Miner did not suffer from the pulmonary impairment normally associated with complicated pneumoconiosis. (D-16 at 7; E-6 at 19-23). An excerpt from Dr. Caffrey's deposition

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[13] In reconciling the fact that he utilizes a 1.0 cm. standard for diagnosing complicated pneumoconiosis and only found evidence of macules of up to .9cm. on the autopsy slides, Dr. Jones explained the Miner had progressive massive fibrosis because none of the slides contained a whole, intact nodule, and that small nodules coalesced into progressive massive fibrosis. (E-5 at 29).

essentially summarizes the analysis and reasoning employed by Drs. Kleinerman and Naeye, in ruling out the presence of complicated pneumoconiosis or progressive massive fibrosis:

> No.1, the findings in the right lung were within lymph nodes not within the lung tissue. And the findings in the left lung, the one area on Slide No. 13, had conglomerate nodules; in other words, nodules which were in very close proximity to one another, and together they measured 1.4 centimeters.
>
> And secondly, it was my opinion that the microscopic appearance of that 1.4 centimeter group of modules was not the microscopic appearance that one most always sees in the complicated pneumoconiosis...microscopically, whatever the size of the lesion is, its microscopic appearance is different than nodular lesions of CWP in the fact that it's a haphazard lesion... . (E-8 at 16-17).

Therefore, only one physician, Dr. Hindman, the prosecting pathologist, opined that the Miner's lungs contained at least one massive lesion caused by a chronic lung disease that was greater than 2.0 cm. in diamter. In determining what weight to accord the opinion of a prosecting physician, the Seventh Circuit has recently declared that, "A scientific dispute must be resolved on scientific grounds, rather than declaring that whoever examines the cadaver dictates the outcome." *Peabody Coal Co. v. McCandless*, 255 F.3d 465, 468 (7th Cir. 2001), *citing Wilder v. Chater*, 64 F.3d 335 (7th Cir. 1995); *Sahara Coal Co. v. Fitts*, 39 F.3d 781 (7th Cir. 1994). Dr. Hindman's failure to provide a gross or microscopic analysis of the lung tissue with his conclusion weakens the probative value of his opinion. Because the majority of the physicians provided extensive analysis of the pathologic evidence, and did not find at least one lesion in the Miner's lungs that met the 2.0 cm. standard, this tribunal finds that complicated pneumoconiosis was not established under prong (b) of §718.304.

Diagnosis by Other Equivalent Means under Prong (c)

Under prong (c), the irrebuttable presumption may be invoked where the miner suffered from a chronic lung disease which when diagnosed by means other than those described in prongs (a) and (b) would be a condition which could reasonably be expected to yield the massive lesions described in prongs (a) and (b). The language indicates that the diagnosis need not actually identify the existence of massive lesions. Instead, it is the disease process behind the formation of massive lesions which must be diagnosed, that disease process being complicated pneumoconiosis. S*ee Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 7, 11 (1996); *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F.3d 250, 255 (4th Cir. 2000). In this case, there are two forms of evidence under prong (c): CT scan interpretations and a medical opinion. *See Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991) (*en banc*).

Three physicians interpreted the CT scans in this case. Dr. Wiot interpreted the CT scans as consistent with simple pneumoconiosis and cancer responsive to chemotherapy, and utilized them to rule out

the presence of complicated pneumoconiosis (D-15, 25; E-7 at 20-24)[14]. Dr. Alexander utilized the CT scan to clarify the existence of a 20 x 10 mm. mass in the upper right lobe, whose shape and adjacent fibrotic reaction, he felt, favored a conglomerate mass of complicated pneumoconiosis (D-22). Dr. Alexander concluded that the right upper lobe mass was probably caused by complicated pneumoconiosis and the left upper lobe mass was suspicious for cancer, but could be caused by complicated pneumoconiosis. Dr. Alexander was unable to form unequivocal conclusions based on the CT scans alone, and ended his opinion with a request that his findings be correlated with pathology of the biopsy specimens. The record contains no evidence that a correlation that would confirm his opinion was ever performed. Dr. Renn also reviewed the CT scans of May 30, 1996 and June 3, 1996 (E-4). Like Dr. Wiot, he found that the CT scans revealed the presence of simple pneumoconiosis and other disease processes, but not complicated pneumoconiosis.

Thus, the CT scan interpretations do not support a finding of complicated pneumoconiosis under this prong. Drs. Wiot and Renn did not find any indication that the Miner suffered from complicated pneumoconiosis or simple pneumoconiosis in such severity that it formed massive lesions. Dr. Alexander did find evidence suggestive of the presence of complicated pneumoconiosis; however, he deferred the making of a definitive conclusion based on the need for pathological correlation, in effect making his opinion equivocal.

Drs. Tuteur provided a reasoned medical opinion based on his review of extensive medical evidence in this case that essentially mirrors the analysis required under §718.304. Dr. Tuteur elaborated on the several factors which led him to opine that the Miner had simple as opposed to complicated coal workers' pneumoconiosis. Referring to the radiographic evidence, Dr. Tuteur first explained that the changes in the Miner's lungs were consistent with, but not diagnostic of progressive massive fibrosis. Acknowledging the possibility of progressive massive fibrosis, Dr. Tuteur explained that he went through the data set, noting that progressive massive fibrosis is irreversible in that it does not get smaller with chemotherapy or any other treatment. He further noted that the Miner was diagnosed with lung cancer and received chemotherapy and radiation therapy, which caused the lesions to get smaller. Accordingly, he concluded that the lesions that initially appeared consistent with progressive massive fibrosis were typical for malignancy. (E-9 at 12). Second, Dr. Tuteur explained that fibrosis due to pneumoconiosis is associated with typical pulmonary function abnormalities, which the Miner did not have (E-9 at 12-13).[15] Third, he noted that there was a consensus among most of the opining pathologists that the standard pathologic criteria for massive fibrosis due to pneumoconiosis was not met. Additionally, he noted that, morphologically, the nodular densities did

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[14] Dr. Wiot also indicated that he utilized Dr. Kleinerman's pathology report in determining that the masses in the Miner's lungs were malignancies rather than large opacities consistent with complicated pneumoconiosis, declaring that, "pathologists have the final answer." (E-7 at 33, 43-44).

[15] Dr. Tuteur explained that progressive massive fibrosis is associated with impairment of gas exchange and a restrictive ventilatory defect, and in this case, the Miner's total lung capacity was greater than normal, and, therefore, there was no restrictive defect, and. his arterial blood gas analyses were normal for a person of his age (E-9 at 13).

not appear to be progressive massive fibrosis. Therefore, he found no reason radiographically, physiologically or pathologically to diagnose progressive massive fibrosis due to pneumoconiosis. (E-9 at 13-14).

The entirety of the evidence under this prong indicates that the Miner did not suffer from complicated pneumoconiosis. Although Dr. Alexander's opinion imputes a diagnosis of complicated pneumoconiosis to the x-rays and CT scans, the lack of requested correlation effectively eliminates its probative force. Dr. Tuteur's well reasoned opinion, which corroborates the opinions of Drs. Naeye, Kleinerman, Caffrey, affirmatively establishes that the Miner did not suffer from the chronic lung disease responsible for or that would evolve into the massive lesions described by prongs (a) and (b). Accordingly, the evidence in this case under prong (c) does not support a finding of complicated pneumoconiosis under §718.304.

Conclusion under §718.304

Since the evidence under the three prongs of §718.304 does not establish the existence of complicated pneumoconiosis, the Claimant is not entitled to invoke the irrebuttable presumption. While x-ray evidence sets the bench mark for diagnosis of complicated pneumoconiosis under the three prongs of §718.304, the Seventh Circuit has held that autopsy evidence is properly accorded more probative value than x-ray evidence in establishing the existence of pneumoconiosis. *McCandless* at 467, c*iting Peabody Coal Co. v. Director, OWCP*, 972 F.2d 178, 182 (7th Cir. 1992). While the x-ray evidence considered in isolation might have met the standard set forth in prong (a), the probative force of that evidence was vitiated by affirmative evidence that the lesions visible on x-ray were not what they appeared to be due to an intervening pathology, cancer. The pathologic evidence, under prong (b), also indicated that the Miner suffered from severe simple pneumoconiosis. However, although its prevalence throughout the Miner's lungs might have provided convincing evidence of complicated pneumoconiosis, the preponderance of the evidence did not reveal the existence of a single lesion that measured at least 2.0 cm. in diameter. The other evidence of record corroborated the findings of the credited pathologists, who ultimately determined that the Miner did not suffer from complicated pneumoconiosis or progressive massive fibrosis.

Entitlement

Claimant has not established that the Miner's death was due to pneumoconiosis or that the Miner had complicated pneumoconiosis. Accordingly, her claim for black lung benefits must be denied.

Attorney's Fee

The award of an attorney's fee under the Act may be approved only in cases in which the claimant is found to be entitled to benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services of an attorney rendered to the Claimant in pursuit of this claim.

ORDER

The claim of Dolores E. Klee for benefits under the Act is hereby denied.

A
EDWARD TERHUNE MILLER
Administrative Law Judge
WASHINGTON, DC

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any interested party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order by filing a notice of appeal with the **Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601.** A copy of the notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.